Utah Department of Health
Office of Primary Care & Rural Health
P.O. Box 142005
Salt Lake City, Utah 84114-2005
(801) 538-6113 FAX: (801) 538-6387
http://health.utah.gov/primarycare

PHYSICIAN
LOAN REPAYMENT (GRANT) APPLICATION

UTAH HEALTH CARE WORK FORCE
FINANCIAL ASSISTANCE PROGRAM

P L E A S E P R I N T

The Utah Health Care Workforce Financial Assistance Program Is Administered Without Regard to Race, Color, Religion, National Origin, Sex, Age, or Status as a Handicapped Individual or Disabled Veteran.

Section I Personal Information

Name:_____ D.O. ☐ M.D. ☐
(Last) (First) (Middle Initial)

Your Specialty:_____

Address:_____
(Number) (Street) (Apartment/Suite Number)

_____
(City) (State/Province) (Country) (Zip Code)

Telephone Number: HOME:(____)_____ WORK:(____)_____

Email Address:_____ FAX:(____)_____

Social Security Number:_____

Place of Birth:_____
(City) (State/Province) (Country)

Are you a citizen or permanent resident of the United States? Yes ☐ No ☐

Are you fluent in any language other than English? Yes ☐ No ☐
If Yes, please specify:_____

Describe, in one page or less, your personal and cultural experiences with underserved populations:

_____

_____

_____

_____

If you need additional space to answer any of the questions in this application,
please limit your response to one page per section,
and print your name and social security number at the top of each page.

Section I: Personal Information (continued)

EVEN IF YOU HAVE ALREADY SELECTED A PRACTICE LOCATION,
PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,

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Optional Items

Birth Date:_____ Ethnicity:_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

If Married, Full Name of Spouse:_____

Children: Yes ☐ No ☐

Section II **Education**

Undergraduate Education

1. Name of Institution:_____

   Complete Address:_____

   _____

   Begin Date:_____ Graduation Date:_____
   Month/Year Month/Year

   Degree(s) Obtained:_____

Medical School Education (provide transcripts)

1. Name of Institution Where you Received your Allopathic or Osteopathic Education:_____

   _____

   Complete Address:_____

   _____

   Begin Date:_____ Graduation Date:_____
   Month/Year Month/Year

   Title of Degree(s) obtained:_____

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Section II: Education (continued)

Postgraduate Training

1. Name of Institution Where You Completed Your Postgraduate Training:_____

   _____

   Name of Program Director:_____

   Complete Address:_____

   _____

   Begin Date:_____ Graduation Date:_____
   Month/Year Month/Year

   Degree(s) Obtained:_____

Additional Postgraduate Training (Please list separately any other professional training locations.)

1. Name of Institution Where You Completed Residency:_____

   Affiliated with What Univesity or Medical Program:_____

   _____

   Name of Program Director:_____

   Complete Address:_____

   _____

   Begin Date:_____ Graduation Date:_____
   Month/Year Month/Year

2. What is(are) Your Specialty(ies):_____

   _____

3. Are You: Board Certified Yes ☐ No ☐ Board Eligible Yes ☐ No ☐

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Section II: Education (continued)

4. If Applicable, Year Certified: _____

5. If Applicable, Year Recertified: _____

6. Sub-Specialty, If Applicable: _____

7. Describe Your Residency or Training Program Experience Outside the Teaching Hospital School. Include Experience Working with Underserved Populations, and Describe the Nature and Length of the Rotation:

_____

_____

_____

_____

Section III Professional Experience

Questions 1 and 2 pertain to any practice experience gained since the completion of your medical training.

1. Outline your professional practice experience over the last five years. Include location, description of setting (solo, group, etc.), length of affiliation with each location, hospital affiliations, and percentage of time expended on providing services associated with Family Medicine, Internal Medicine, Obstetrics, Pediatrics, and Emergency Medicine.

_____

_____

_____

_____

_____

_____

_____

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Section III Professional Experience (continued)

2. Describe your client profile up to the last five years, including information on age mix, underserved populations, percent of Medicaid patients, and uninsured patients (if known):

_____

_____

_____

_____

_____

_____

3. Employment History: Provide name and contact information of the director or official of each site where you have practiced in the last five years since completing your medical training:

a. Name:_____ Title:_____

Address:_____
(Complete Site Name)

_____
(Number) (Street) (Suite Number)

_____
(City) (State/Province) (Country) (Zip Code)

Telephone Number:(____)_____ Fax Number:(____)_____

Allocation of Time (Hours per week):

Clinic Care: Administration:_____ Clinical/Practice Based:_____ Hospital Based:_____

Teaching:_____ Other (Specify):_____

Begin Date:_____ End Date:_____
Month/Year Month/Year

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Section III Professional Experience (continued)

b. Name:_____ Title:_____

Address:_____
(Complete Site Name)

_____
(Number) (Street) (Suite Number)

_____
(City) (State/Province) (Country) (Zip Code)

Telephone Number:(____)_____ Fax Number:(____)_____

Allocation of Time (Hours per week):

Clinic Care: Administration:_____ Clinical/Practice Based:_____ Hospital Based:_____

Teaching:_____ Other (Specify):_____

Begin Date:_____ End Date:_____
Month/Year Month/Year

4. List states in which you currently hold, or have held, a license to practice medicine (***Note: You must be eligible to obtain an unrestricted license to practice in the State of Utah.***)

_____

5. Have you ever been subject to any disciplinary action or licensure restrictions? Yes ☐ No ☐

If Yes, by whom (Please Explain):_____

_____

_____

_____

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Section III Professional Experience (continued)

Other Training

Describe any other pertinent training (Include experience with underserved populations):

1. Location:_____
(Business Name)

Name of Supervisor/Director:_____ Phone: (____)_____

Complete Address:_____
(Complete Business Name)

_____

Begin Date:_____ End Date:_____
Month/Year Month/Year

Describe Experience:_____

_____

2. Location:_____
(Business Name)

Name of Supervisor/Director:_____ Phone: (____)_____

Complete Address:_____
(Complete Business Name)

_____

Begin Date:_____ End Date:_____
Month/Year Month/Year

Describe Experience:_____

_____

_____

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Section IV Professional References

1. Reference Name:_____ Position or Title:_____

   Complete Address:_____

   _____

   Telephone Number:(____)_____

2. Reference Name:_____ Position or Title:_____

   Complete Address:_____

   _____

   Telephone Number:(____)_____

3. Reference Name:_____ Position or Title:_____

   Complete Address:_____

   _____

   Telephone Number:(____)_____

Section V Personal References

Please give the names and addresses of **THREE (3)** persons, not related to you by blood or marriage, who are qualified to give information regarding your character or financial need.

1. Reference Name:_____ Relationship to Applicant:_____

   Complete Address:_____

   _____

   Telephone Number:(____)_____

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Section V Personal References (continued)

2. Reference Name:_____ Relationship to Applicant:_____

   Complete Address:_____

   _____

   Telephone Number:(____) _____

3. Reference Name:_____ Relationship to Applicant:_____

   Complete Address:_____

   _____

   Telephone Number:(____) _____

Section VI Loan Repayment or Scholarship Service Commitments

1a. Do you have any existing service obligations? Yes ☐ No ☐

   If Yes, Name of Program:_____

   Complete Address:_____

   _____

   Contract Entity:_____

   Telephone Number:(____) _____

   Terms of obligation:_____

   _____

   _____

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Section VI Loan Repayment or Scholarship Service Commitments (continued)

1b. Are you in default of this or any other obligation? Yes ☐ No ☐

If Yes, describe circumstances:_____

_____

2. What date will you be available to begin practice under the Utah Health Care Workforce Financial Assistance Program?_____
Month/Day/Year

Section VII Practice Preferences

1. If applicable, please describe preference of practice location in Utah in terms of: type of practice (solo, group, etc.), maximum distance from a hospital, size of community, preferred area in Utah, types of services available in community, climate, geographic features, recreational outlets, etc. *NOTE: If you already have an agreement with a designated Utah practice location, please state name of site location, name of contact person, and nature of your agreement.*

_____

_____

2. List the most important factors to you when selecting a practice location:

#1 _____

#2 _____

#3 _____

#4 _____

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P L E A S E P R I N T

Section VII Practice Preferences (continued)

3. Describe in one page or less, the characteristics you possess that would make you a good candidate to receive loan repayment for an underserved population practice:

_____

_____

4. If chosen for this Program, are you willing to provide care to Medicaid, and indigent patients?
   Yes ☐ No ☐
5. How many years of service are you willing to commit? 2 years ☐ 3 years ☐ 4 years ☐
6. Please list any other competencies or awards not referred to in this application:

_____

Please include a copy of your curriculum vitae and State of Utah license along with this application.

CERTIFICATION

I certify that the information I have provided in this application is accurate and complete to the best of my knowledge and belief. I understand my responses may be investigated and any willfully false representation is sufficient cause for rejection of this application.

Signature:_____ Date:_____
(Sign Full, Legal Name - - In Ink)

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INFORMATION RELEASE

I Am Applying for an Educational Loan Repayment or Scholarship Grant Through the Utah Health Care Workforce Financial Assistance Program.

I Consent to the Release to the Utah Department of Health Private, Sensitive, Privileged, and Otherwise Confidential Information about Me to the Extent That it Bears upon Any of the Following: My Education; Internship, Postgraduate, Preceptorship, or Residency Speciality Training; Board Certification; Experience; Professional Conduct; Ethics; Ability to Work with Others; Hospital and Other Affiliations; Disciplinary Actions; Malpractice Claims History; Litigation Experience; State Licensure; and Controlled Substance Licensure. I Intend That this Consent Include All Information That Reflects on My Ability to Safely, Competently, and Professionally Perform the Professional Activities Required of Me Should I Receive a Grant or Scholarship under this Program.

I Agree That this Consent Extend to All Persons, Institutions, and Entities That Have Such Information about Me, Including: Colleges, Universities, Professional Societies, Hospitals, Speciality Boards, Practice Groups, Clinics, Insurance Companies, Partnerships, Professional Corporations, and Employers, and to Persons and Committees Associated with Any of These. I Also Give My Consent for All Such Persons, Institutions, and Entities to Express Their Evaluation of Me and Make Recommendations about My Professional Skill, Conduct, and Ability to Perform Clinical Duties in the Area for Which I Have Applied.

I Intend That a Copy of this Document May Be Relied upon as If it Were the Original.

Legal Signature of Applicant:_____ Date:_____

Printed Name of Applicant:_____
(Type or Print Clearly)

Social Security Number of Applicant:_____
(Type or Print Clearly)

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Section VIII Loan Information

☐ 1. **Complete Section A.** Return this Section to this Program at the Address Listed Above.

☐ 2. **Complete and Send Section B.** to Your Lender, Or, Have Your Lender Send a Copy of the Loan Information Directly to this Program, Indicating the Total Unpaid Principal Balance; and for Each Loan, the Disbursement Date and the Type of Loan.

If Section B Is Filled Out, Be Sure to Write Your Name and Social Security Number on the Form.

☐ 3. An Application Cannot Be Processed until Section B, or the Information from the Lender(s) Is Received by Us.

☐ 4. You Are Responsible for Following up with Your Lender to Assure That the above Information Is Sent.

☐ 5. If Your Educational Loans Have Been Sold to Another Lender, or Consolidated by a Loan Marketing Association, Submit the Request for Loan Information to **That Lender**, Not to Your Original Lender.

☐ 6. To Assure That Section A and Section B Can Be Matched upon Receipt, Please Write the Academic Period Covered by the Loan in the Upper Right Corner of Section B.

Section A.

Name of Lending Institution: _____

Complete Address: _____

_____

Telephone Number: (____) _____ Fax Number: (____) _____

Purpose of Loan: _____

Type of Loan: _____

Address Where Payments Are Sent (If Different from Above): _____

_____

Warning
Any Person Who Knowingly Makes a False Statement or Misrepresentation in this Loan Repayment Application, Fraudulently Obtains Repayment for a Loan, or Commits Any Other Illegal Action in Connection with this Transaction Is Subject to a Fine or Imprisonment. I Have Read this Statement and Understand its Contents.

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Section VIII: Loan Information (continued)

Amount of this Loan You Are Requesting to Have Repaid by this Program: $_____

Academic Period Covered by this Loan from _____ To _____
((Month/year)) ((Month/year))

Loan Disbursement Dates (If Known): _____

Note: *Loans Without Appropriate Documentation, Loans Paid in Full, Delinquent Loans, and Loans from Friends or Relatives Which Are Undocumented by a Contract Notarized at the Time of the Making of the Loan,* ***May Not*** *Qualify for Repayment under this Program.*

Certification by Applicant/borrower

(Must Be Notarized)

I Apply to Enter into an Agreement with the State of Utah for Repayment of All or Part of My Educational Loans Submitted with this Application. Repayment May Be Made Only for Educational Expenses Defined in the Utah Health Care Workforce Financial Assistance Program Rule as Tuition, Fees, Books, Supplies, Educational Equipment and Materials, and Reasonable Living Expenses. I Authorize the Lender(s) Named above to Release Information on My Loan(s) to the Administrator of the Utah Health Care Workforce Financial Assistance Program.

_____
Applicant's Signature

State of Utah)
SS)
County of _____)

On this _____ Day Of _____, 20_____,

_____ Personally Appeared Before Me,

_____, A Notary Public, and Signed this Application,

Of Which this Acknowledgment Forms a Part.

_____
Notary Public

_____
Residing at

My Commission Expires on _____

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Section B. **Loan Data and Certification**
(To Be Completed by Lender)

Applicants Social Security Number: _____

_____ Is Applying for a Grant to Repay Educational Loans
(Applicants Name)

Through the State of Utah's Utah Health Care Workforce Financial Assistance Program. Please Provide the Program with the Information Requested Below.

1. Original Amount of Loan:$_____

2. Current Balance:$_____ Date of this Balance:_____
(Month/year)

3. Interest Rate:_____% Simple Interest? Yes ☐ No ☐

4. If Other than Simple Interest, Explain:_____

5.

Disbursement Date		**Type of Loan (E.g. Subsidized Stafford)**		**Amount for Each Loan That You Service**	
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$

3. Is Any Loan (Or Loans) Listed above in Default? ☐ Yes ☐ No

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Section B. (Continued) **Loan Data and Certification**
(To Be Completed by Lender)

Lender's Certification

The Undersigned States That, to the Best of His/her Knowledge, the Loan(s) Identified in this Section Is a Bona Fide, Legally-enforceable Loan(s) Made for the Purpose of Meeting the Borrower's Cost of Attending a School or Institution where they obtained their Allopathic or Osteopathic Education

Name of Lending Institution: _____
(Please Print)

Complete Address of Lending Institution: _____
(Number) (Street) (Suite Number)

_____
(City) (State/province) (Country) (Zip Code)

_____

Telephone Number:( ) _____

Fax Number:( ) _____

Name/title of Officer: _____
(Please Print)

Signature: _____ Date: _____

Return this Completed Form To:
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Utah Department of Health
P.O. Box 142005
Salt Lake City, Utah 84114-2005
Telephone: (801) 538-6113 Fax: (801) 538-6387

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Check List:

Have You Included Each of the Following?
If Not, Your Application May Be Delayed or Denied.

Please Assure That Each of the Boxes below Are Checked and this Check List Is Returned with Your Completed Application.

☐ Have All Sections of the Grant Application Been Completed? Sections "Not Applicable" Should Have Been Marked "Na." If Not, Your Grant Application May Be Delayed or Denied.

☐ Submit a **Completed** Application for Educational Loan Repayment to the Utah Department of Health, Including:
a. personal Information and
b. loan Certification.

☐ A Copy of Your Curriculum Vitae **must** Be Included in Your Application.

☐ Be a Physician Who Has a License in Good Standing to Practice in the State. You **must** Provide a Copy of Your Current, Unrestricted License to Practice Medicine in the State of Utah.

☐ Be Available to Begin Service, **Full-time** at an Eligible Employment Site Within One Month of Entering into a Contract with the Utah Department of Health.

☐ Provide the Utah Department of Health with Documented Evidence of Employment. A Copy of Your Signed Contract or Signed Employment Agreement with the Employment Site **must** Be Provided.

☐ The Information Release Form of this Application **must** Be Signed and Dated.

☐ **Please Note:** You Are Responsible for Following up with Your Lender to Assure That the Information Is Sent.

☐ Submit All Documentation Together. Incomplete Applications Will Be Returned. When All Materials Have Been Submitted, Funding Priority Will Then Be Assigned.

☐ Complete Applications must Be Submitted by the Following Due Date: **MARCH 1 OF EACH YEAR**. Applications Not Received by the Due Date Will Not Be Processed.

Note: Loan repayment grants are subject to federal, state, and local taxes.
If you have additional questions, please consult a tax professional.